



SUPERIOR SCANNING SERVICE
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 info@superioscan.com
 www.superioscan.com

Holter Client Enrollment Form

Date: _____
 Practice Name: _____
 Physician Name: _____ Contact Name: _____
 Address _____ City: _____ State: _____ Zip: _____
 Office Phone: _____ Office Fax: _____
 Email Address: _____ @ _____

Physician Notification

Immediately notify abnormal findings: During business hours: No ___ Yes ___ Fax ___ email ___ Phone ___
 After business hours: No ___ Yes ___ Fax ___ email ___ Phone ___

Abnormal Findings

Sinus Tachycardia > 150 bpm	Idioventricular Rhythm	SVT > 30 sec
New onset Atrial Fib/Flutter	Sinus Bradycardia <40	Atrial Fib/Flutter > 130
VTAC > 4 beats	Ventricular Fibrillation	Junctional Rhythm > 30 sec
Asystole	Wide QRS Tachycardia > 4 beats	Heart Blocks (all types)
Pauses > 2.5 seconds	Complete Heart Block	PM Sense/Capture Failure

Add, Delete, or modify any of the above: _____ **MD initial here** _____

****Must have High Speed Internet Access and available USB port for uploading scans****

- Fee for scanning \$ _____ per scan. **MD initial** _____
- If volume is 10 or more scans per month, SSS will absorb the cost of a Magic Vortex entry-level account.
- If volume is less than 10 scans per month, the Magic Vortex fee will be added to the bill. **MD initial** _____
- Either party can revoke this agreement, at any time, with 30 day written notice.
- Account billed monthly, payment is net 15 days. **MD initial** _____
- Holter reports are the findings made by a technician and must be reviewed by a licensed physician.
- SSS will provide staff training if necessary for data transmission.
- Digital Holter monitor is the property of SSS and must be returned at termination of contract.

 Signature of Client

 Signature of SSS Representative

 Printed Name

 Date Signed